

5874

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Millington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Millington</b> X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>1</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Frank</b> First <b>Kostick</b> Last		4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 20, 1882</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (State or foreign country) <b>Hungary</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-03-2496A</b>	
17. INFORMANT <b>Frank Gonzales</b>		nd Address <b>159 E. 98 St. New York, 28, N.Y.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Virus Pneumonia</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Degeneration of the heart muscle</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 weeks</b> <b>5 years</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Apr 5, 1960</b> , to <b>May 21, 1960</b> , that I last saw the deceased alive on <b>May 20, 1960</b> , and that death occurred at <b>GP</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>MILLINGTON, MD.</b> DATE SIGNED <b>5.23.60</b> ACTUAL SIGNATURE <b>G. F. Z. KORALEWSKI</b> M.D. PHYSICIAN'S NAME (Type) <b>G. F. Z. KORALEWSKI</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May, 24, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Dennis Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Rural Galena, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Kellner, Millington, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 25 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. DEPARTMENT OF JUSTICE

5875

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>KENT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>KENT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL, WORTON</b>		c. LENGTH OF STAY IN 1b <b>10 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CARL</b> First <b>PAUL</b> Middle <b>MYERS</b> Last		4. DATE OF DEATH <b>MAY</b> Month <b>25</b> Day <b>1960</b> Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 20, 1875</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARM</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GENERAL</b>	
11. BIRTHPLACE (State or foreign country) <b>Md - KENT Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN CHRISTIAN MYERS</b>		14. MOTHER'S MAIDEN NAME <b>ANNA MARGARET REESE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>ANNA MYERS WELCH</b>		Address <b>WORTON, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 UREMIA</b> DUE TO <b>PNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO <b>5 years +</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTHRITIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>NOVEMBER, 1954</b> , to <b>MAY 23, 1960</b> , that I last saw the deceased alive on <b>May 23, 1960</b> , and that death occurred at <b>8:12 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Florence Deringer Joyce</b> M.D.		ADDRESS (Street, city or town, state) <b>Worton, Md</b>	
PHYSICIAN'S NAME (Type) <b>FLORENCE DERINGER JOYCE</b>		DATE SIGNED <b>5/25/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5-28-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CHESTER CEMTY</b>		22d. LOCATION (City, town, or county) (State) <b>CHESTERTOWN MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Victor N. Kennedy</b>		ADDRESS <b>STILL POND, MD.</b>	
24a. REC'D BY REGISTRAR <b>MAY 31 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kennedyville</b>		c. LENGTH OF STAY IN 1b <b>8 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Groves Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Dora</b> Middle <b>May</b> Last <b>Pennington</b>		4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 23, 1876</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months <b>84</b> Days <b>84</b> Hours <b>84</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>County Schools</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Daniel Loller</b>		14. MOTHER'S MAIDEN NAME <b>Ella Hicks</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>	
17. ADDRESS <b>735 Beall Ave. Rockville, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis generalisata</b> <b>422.1</b> DUE TO <b>Degeneration of the heart muscle</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bed sores</b> (c) <b>Bed sores</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 29, 1959</b> to <b>May 16, 1960</b> that I last saw the deceased alive on <b>May 10, 1960</b> and that death occurred at <b>19-P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>GEZA KORALEWSKI</b>		ADDRESS (Street, city or town, state) <b>MILLINGTON, MD</b>	
PHYSICIAN'S NAME (Type) <b>GEZA KORALEWSKI</b>		DATE SIGNED <b>5.16.60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/19/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Still Pond Cemty.</b>		22d. LOCATION (City, town, or county) (State) <b>Still Pond, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Victor N. Kennedy</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 18 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## CERTIFICATE OF DEATH

Reg. Dist. No.

5872

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>37 Chestertown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Annes</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>VICTOR POWER PENNINGTON</b>				4. DATE OF DEATH Month Day Year <b>May 8 1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 19, 1892</b>		9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming &amp; Military</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Millington, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Liston Pennington</b>				14. MOTHER'S MAIDEN NAME <b>Annie Stevens</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW1 and WW 11 115-03-1247</b>		17. INFORMANT <b>Patient &amp; Hospital records, Chestertown, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>Probable terminal Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>1 month</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute psychosis- terminal &amp; Uremia</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 10</b> , 19 <b>60</b> , to <b>May 8</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>May 8</b> , 19 <b>60</b> , and that death occurred at <b>9:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chestertown Md.</b> DATE SIGNED <b>May 9, 1960</b>							
ACTUAL SIGNATURE <b>Robert W. Farr</b>				M.D. <b>Chestertown Md.</b>			
PHYSICIAN'S NAME (Type) <b>ROBERT W. FARR</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/11/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SODLERSVILLE CEM. SODLERSVILLE</b>		22d. LOCATION (City, town, or county) (State) <b>MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 13 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Farris</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







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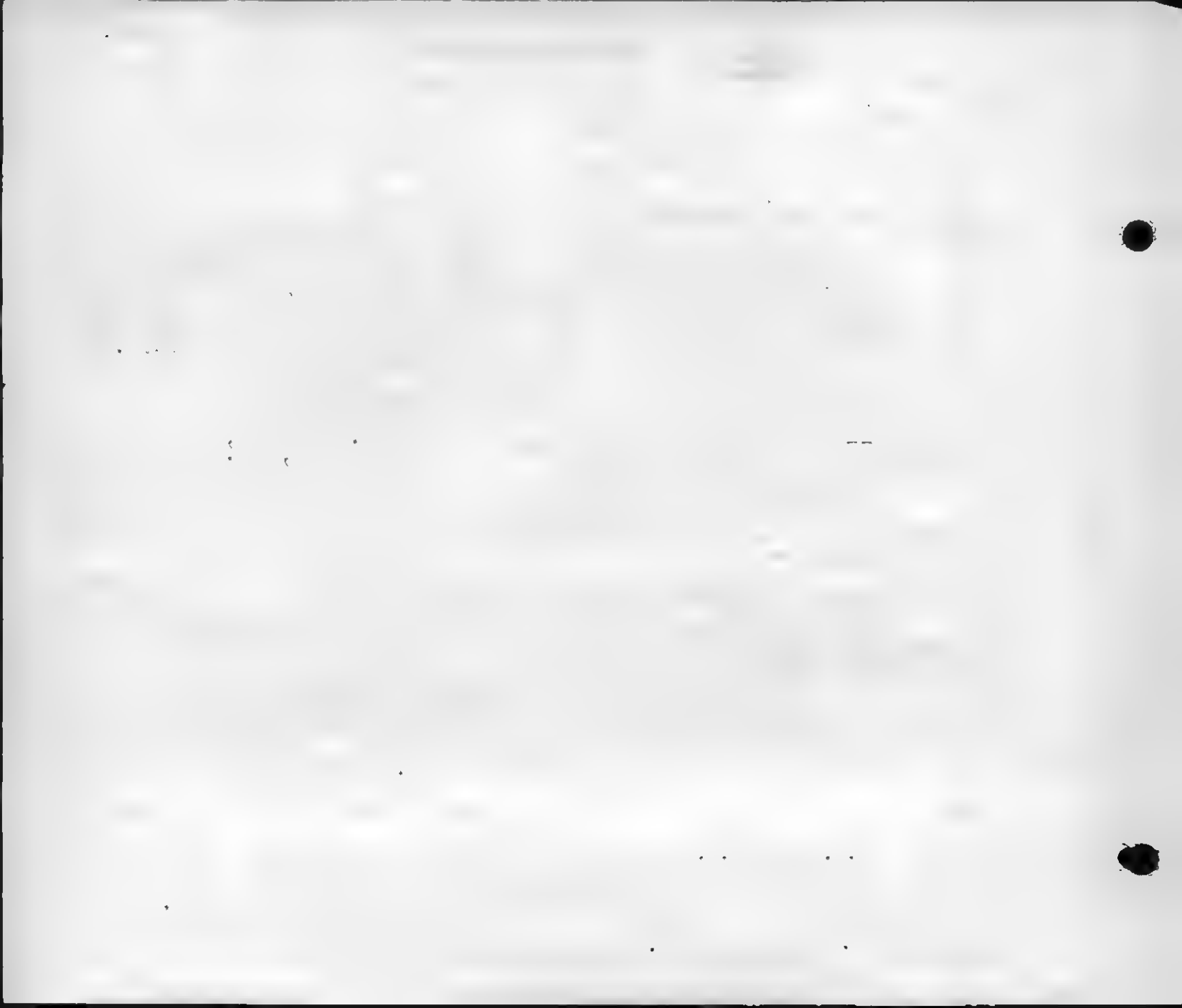
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Kent</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>27 Chestertown</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne's Hospital</b>			d. STREET ADDRESS <b>314 Park Row</b>		
3. NAME OF DECEASED (Type or print) First <b>Clara</b> Middle <b>Frances</b> Last <b>Rice</b>			4. DATE OF DEATH Month <b>5</b> Day <b>26</b> Year <b>1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/15/82</b>	9. AGE (In years lost birthday) <b>77</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>James Lewis</b>		
14. MOTHER'S MAIDEN NAME <b>Ella Schoone</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO. <b>217 20 0780</b>			17. INFORMANT <b>Mary R. VanDyke, daughter.</b> <b>Chestertown, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Circulatory collapse</b> DUE TO <b>Shock, postoperative</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Intestinal obstruction, partial</b> DUE TO (c) <b>Annular carcinoma of transverse colon</b>					INTERVAL BETWEEN ONSET AND DEATH <b>30 hours</b> <b>30 hours</b> <b>10 days</b> <b>6 months?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			20g. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>5-15</b> , 19 <b>60</b> , to <b>5-26</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>5-26-60</b> , 19 <b>60</b> , and that death occurred at <b>6:40p.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chestertown, Maryland</b> DATE SIGNED <b>5-27-60</b>					
ACTUAL SIGNATURE <b>A.C. Dick</b> M.D.					
PHYSICIAN'S NAME (Type) <b>A.C. Dick, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 29/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Marvin V. Williams, Md.</b> <b>-Chestertown</b>			
24a. REC'D BY REGISTRAR DATE <b>JUN 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Chestertown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD Quaker Neck</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> X			
3. NAME OF DECEASED (Type or print) <b>George First Middle Lost</b> <b>George W. Smith</b>				4. DATE OF DEATH <b>May 28, 1960</b> Month <b>May</b> Day <b>28</b> Year <b>19</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 2, 1894</b>	
9. AGE (In years last birthday) yrs. <b>66</b>		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Caretaker for farm</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>(Laborer)</b>	
11. BIRTHPLACE (State or foreign country) <b>Kent Co. Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John H. Smith</b>				14. MOTHER'S MAIDEN NAME <b>Ella V. Wright</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>217-30-8478</b>		17. INFORMANT <b>Mrs. Pearl Smith</b> Address <b>RFD Quaker Neck Chestertown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>422.1</b> DUE TO <b>Arterio Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardio Vascular</b> (c) <b>Cardio Vascular</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>April 7, 1960</b> to <b>May 28, 1960</b> that I last saw the deceased alive on <b>May 21, 1960</b> and that death occurred at <b>100 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rock Hall, Md.</b> DATE SIGNED <b>5/30/60</b>							
ACTUAL SIGNATURE <b>Norbert C. Nitsch</b> M.D.				PHYSICIAN'S NAME (Type) <b>Norbert C. Nitsch</b> <b>Rock Hall, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 1, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>POmona Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>RFD Chestertown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest W. Walker</b>				ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 2 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>			

WE BELIEVE STATE DEPARTMENT OF HEALTH - BACWORLD IS



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**5878 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05846

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <span style="float:right">MARYLAND</span>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown (RFD)</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RFD Fairlee</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Chestertown (RFD Fairlee)</b>	
		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) <b>Rachel Elizabeth Willis</b>		4. DATE OF DEATH Month <b>May</b> Day <b>11</b> , Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 11, 1905</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teller in Bank</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William B. Willis</b>		14. MOTHER'S MAIDEN NAME <b>Lena Gale</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-10-0273</b>	
17. INFORMANT <b>L. Chap Willis</b>		Address <b>RFD Chestertown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Carbon Monoxide Poisoning</b> <b>9773.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>short</b>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Found on automobile in closed garage</b>	
20c. TIME OF INJURY Month, Day, Year <b>5/11 1960</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Chestertown RFD Md.</b>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Robert W. Farr</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Robert W. Farr</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DATE SIGNED <b>5/11/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 13, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Chestertown, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 13 '60</b>	
ADDRESS <b>Chestertown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

